PATIENT DATA FORM

First Name:	
Middle Initial:	
Last Name:	
Nickname:	

Social Security# - last 6 digits only:	
Date of Birth:	
Age:	
Gender:	Male O Female O

Employer:	
Mail Code:	
Work Phone:	
Cell Phone:	
Home Phone:	
Fax:	

Building/Room:	
Shift:	O 1 O 2 O 3 O TDY
Job Description:	
Supervisor's Name:	
Supervisor's Phone:	

Work email: _____

Have you ever been to RehabWorks before?: YES O NO O

Place injured: O Home O Work O Sport O Other

Is this a Workers' Comp Injury: YES O NO O

COMPLETE THIS SECTION *ONLY* IF THIS IS A WORKERS' COMP INJURY

Workers' Comp Name:	
Workers' Comp Phone:	
Workers' Comp Fax:	

Statement of Consent for Release of Information

I authorize RehabWorks to release the medical information contained in my patient records pertaining to the workers' compensation injury for which I am currently being treated by RehabWorks to my physician and/or workers' compensation representative for the purpose of progress notes and/or case management.

Employee Signature _____ **Date** _____

Medical History Form

Name: _____ **Date:** _____

Do you currently have or have you had problems with:

Select one		Please provide details
◯ Yes ◯ No	Angina/Chest pain	
◯ Yes ◯ No	Arthritis	*Area(s):*
◯ Yes ◯ No	Asthma	
◯ Yes ◯ No	Back Injury	*Type:*
◯ Yes ◯ No	Balance problems	
◯ Yes ◯ No	Blackout/Fainting	
◯ Yes ◯ No	Bleeding problems	
◯ Yes ◯ No	Blood clots or Phlebitis	
◯ Yes ◯ No	Bone Fractures	*Area(s):*
◯ Yes ◯ No	Cancer	*Area(s):*
◯ Yes ◯ No	Cardiac Catheterization	
◯ Yes ◯ No	Cough	
◯ Yes ◯ No	Diabetes	*Type:*
◯ Yes ◯ No	Dislocation/Subluxation	*Area(s):*
◯ Yes ◯ No	Epilepsy/Seizures	
◯ Yes ◯ No	Gout	*Area(s):*
◯ Yes ◯ No	Heart Attack	
◯ Yes ◯ No	Heart Failure	
◯ Yes ◯ No	Heart Murmur	
◯ Yes ◯ No	Heart Valve problems	
◯ Yes ◯ No	Heartburn	
◯ Yes ◯ No	Hepatitis/Jaundice	
◯ Yes ◯ No	Hernias	*Area(s):*
◯ Yes ◯ No	High Blood Pressure	
◯ Yes ◯ No	Infectious Disease	
◯ Yes ◯ No	Kidney problems	
◯ Yes ◯ No	Migraines/Headaches	
◯ Yes ◯ No	Motor Vehicle Accident	
◯ Yes ◯ No	Neck Injury	*Type:*
◯ Yes ◯ No	Numbness/Tingling	*Area(s):*
◯ Yes ◯ No	Osteoporosis/Penia	
◯ Yes ◯ No	Palpitations	
◯ Yes ◯ No	Prednisone usage	
◯ Yes ◯ No	Prior Cardiac Surgery	
◯ Yes ◯ No	Prostate	
◯ Yes ◯ No	Scoliosis	
◯ Yes ◯ No	Shortness of breath	
◯ Yes ◯ No	Sprain (ligament)	
◯ Yes ◯ No	Stomach ulcers	
◯ Yes ◯ No	Strain (muscle/tendon)	
◯ Yes ◯ No	Stroke	
◯ Yes ◯ No	Tuberculosis	
◯ Yes ◯ No	Other	

Additional Comments: _____

Medical History Form (pg.2)

Injury History

_____ Onset of symptoms

Briefly describe why you're being treated at RehabWorks:

_____

_____

☐ N/A **Medications**

Please list any prescription or over-the-counter medicines that you are currently taking:

_____

_____

☐ N/A **Allergies**

Please list any known allergies to medications:

_____

_____

☐ N/A **Past Surgical History**

Surgery:	Year:	Surgery:	Year:
1. _____	_____	6. _____	_____
2. _____	_____	7. _____	_____
3. _____	_____	8. _____	_____
4. _____	_____	9. _____	_____
5. _____	_____	10. _____	_____

Exercise History

Please select one: ◯ Daily ◯ Weekly ◯ Monthly ◯ Rarely ◯ Never

Type of Exercise/Physical activity: _____

Smoking History

Currently Smoking? ☐ Yes ☐ No _____ packs/day for _____ year(s)

Quit Smoking? ☐ This year ☐ >1 ☐ >5 years ☐ >10 years

Previously Smoked _____ packs/day for _____ year(s)

Medical Hx Reviewed by _____ **MS, ATC, LAT** **Date** _____

Reviewed by Supervising Physician _____ **Date** _____

Outcome Assessment

Please rate the following statements below between POOR (0) and EXCELLENT (4).

Patient Name: _____

Injury/Surgery: _____

Body Part: _____

POOR (0) - FAIR (1) - GOOD (2) - GREAT (3) - EXCELLENT (4)

	Date: First day of rehabilitation	Date: Last day of rehabilitation
How would you rate your overall general health?	0 1 2 3 4	0 1 2 3 4
How would you rate the current condition of the specific body part we are treating?	0 1 2 3 4	0 1 2 3 4
How would you rate your current ability to complete activities of daily living such as: driving, walking, sitting, sleeping, dressing, house chores, stairs, etc.?	0 1 2 3 4	0 1 2 3 4
How would you rate your ability to complete your daily work tasks	0 1 2 3 4	0 1 2 3 4
How would you rate your ability to perform physical activities such as sports, hobbies, exercise, etc.?	0 1 2 3 4	0 1 2 3 4

ONLY FILL OUT BELOW AT TIME OF DISCHARGE

POOR (0) - FAIR (1) - GOOD (2) - GREAT (3) - EXCELLENT (4)

How would you rate the services and facilities of RehabWorks?	0 1 2 3 4
How would you rate the professionalism and skills of your Athletic Trainer?	0 1 2 3 4
How would you rate the outcome of your rehabilitation?	0 1 2 3 4